SPOTLIGHT ON
MARYLAND

UTILIZATION AND SPENDING IN CONSUMER-DIRECTED HEALTH PLANS

A Look at the Small Group Market in Maryland

WHAT IS A CONSUMER-DIRECTED HEALTH PLAN? In recent years, as growing emphasis has been placed on reducing U.S. health care spending, consumer-directed health plans (CDHPs) have been offered as one possible solution. Also referred to as high-deductible health plans, these health insurance products with high deductibles are often accompanied by health savings accounts (HSAs) or health reimbursement arrangements (HRAs).[1] HSAs allow individuals to make tax-deductible contributions to savings accounts that can be withdrawn without penalty to purchase health care-related goods and services. As an additional incentive, any earnings accumulated in the savings accounts are not taxed. Proponents of CDHPs argue that the high deductible encourages individuals to become more cost-conscious in their health care utilization, because they are bearing the upfront cost of decisions to use care. However, there are others who object to CDHPs on the basis that the tax structure and incentives built into HSAs make them most attractive to those with high incomes and those who are healthy, so that these individuals reap tax advantages but overall health care spending is not reduced.[2]

Although high-deductible plans have been around for years in the nongroup market, only since the passage of the 2003 Medicare Prescription Drug, Improvement, and Modernization Act has a tax incentive been tied to plans that meet IRS-mandated minimum requirements. In 2009, the minimum annual in-network deductible for these policies is $1,150 for single and $2,300 for family policies. The maximum out-of-pocket (OOP) spending is $5,800 for single policies and $11,600 for family policies.[3] However, the average deductible for CDHPs offered by employers is much higher than the minimum, and two-thirds of employers report making no contributions to their employees' HSAs. Consequently, low-income workers with CDHPs tend to bear a much larger financial burden for OOP payments than do low-income workers with more traditional health plans.[4]

This Spotlight relies on data from the Maryland Medical Care Data Base (MCDB), which includes data for Maryland's privately insured, less-than-65 years of age population. For the purposes of classifying users by whether they are in a CDHP, data are available only for persons in this population who have used a professional health care service in the time period of interest. These individuals are referred to throughout the Spotlight as "users." We also draw on data on persons enrolled in or covered by insurance plans, regardless of whether they use services. These individuals are referred to as "enrollees." The data reported have been submitted to the Maryland Health Care Commission by insurers. The proportion of enrollees who use services provides some suggestive information about a group's average inclination to use health care services and possibly about how costly a population may be to cover.

[1] HRAs are distinct from HSAs in that the former are employer-established and can be funded only with employer contributions; any money in the account stays with the employer if the employee leaves. HSAs, in contrast, are owned by the employee.

[2] Blumberg LJ and Clemens-Cope L. "Health Savings Accounts and High-Deductible Health Insurance Plans: Implications for Those with High Medical Costs, Low Incomes, and the Uninsured," *Timely Analysis of Immediate Health Policy Issues* series, Robert Wood Johnson Foundation, January 2009.

[3] "Treasury, IRS Issue 2009 Indexed Amounts for Health Savings Accounts." U.S. Department of the Treasury Press Release, May 13, 2008.

[4] Blumberg and Clemens-Cope, op. cit.

GROWING CDHP ENROLLMENT IN MARYLAND AND IN THE UNITED STATES OVERALL Nationally, CDHPs are a growing phenomenon. As of September 2008, 8 percent of covered workers in the United States were enrolled in a CDHP, double the enrollment in 2006.[5] The extent to which firms are making high-deductible plans with savings accounts available to their employees also is increasing on a national level. Of those employers offering health benefits in 2008, 13 percent offered a CDHP to their employees, up from 7 percent in 2006. While larger firms are more likely to offer these products than are smaller firms, employees in smaller firms are more likely to choose CDHPs than are large-firm workers.

Here in Maryland, use of these plans also has grown fairly dramatically.[6] Of those in the less-than-65 years of age, privately insured population in Maryland in 2007, medical care users enrolled in CDHPs accounted for approximately 7 percent.[7] In the relatively short time since the coupling of CDHPs with tax-advantaged HSAs in 2004, the number of medical care users enrolled in CDHPs in 2007 had reached 141,023 persons (see Table 1).[8] Growth has been spurred by a number of factors—insurers have increasingly offered CDHPs with HSAs, and the public has become more familiar with them. A major contributing factor in Maryland has been activity in the small group market, with the regulations governing the Comprehensive Standard Health Benefit Plan (CSHBP) modified to allow for preferred provider organization (PPO)/HSA offerings as of July 1, 2004, and health maintenance organization (HMO)/HSA offerings two years later. Table 1 provides information about the subset of enrollees who used professional medical services during 2007. Among nonelderly, privately insured users of professional medical services, the small group market covers one in five of those in a CDHP plan, compared with one in eight of those in a non-CDHP plan. According to insurer counts of enrollees submitted to the Maryland Health Care Commission (MHCC) (rather than users), nonelderly enrollment in CDHPs—in the small group market alone—reached 94,215 covered lives in 2007, accounting for 22 percent of small group market enrollees in Maryland. For the insurer with the largest enrollment in this market segment, this represented more than a tripling of the number of covered lives since 2006. The growth in CDHP enrollment continued throughout 2008. The remainder of this Spotlight focuses on the nonelderly in the small group segment of the market.

TABLE 1. Number of Nonelderly, Privately Insured Users in Maryland: CDHP and Non-CDHP and Distribution by Coverage Type, 2007

All Privately Insured Users	CDHP	Non-CDHP
Number of users, enrolled at end of year	141,023	2,037,170
Number of users, enrolled all year	98,060	1,752,734
COVERAGE TYPE FOR USERS ENROLLED ALL YEAR		
Individual Plan	3.3%	6.1%
Large Private Employer Plan	74.7	38.5
Public Employee Plan	0.9	42.7
CSHBP (small group market)	21.1	12.4

SOURCE: 2007 Maryland Medical Care Data Base

NOTE: Because enrollment dates vary, and employers and individuals change offerings/coverage during the year, the number of users at a point in time will be greater than the number of users enrolled for a full year. Distribution by coverage type is for full-year users.

A CLOSER LOOK AT CDHP ENROLLEES IN MARYLAND'S SMALL GROUP MARKET Within the small group market where CDHPs are relatively widely offered, there were 94,215 nonelderly CDHP enrollees, accounting for 22.4 percent of all enrollees less than 65 years of age (Table 2). The composition of the CDHP enrollee population compared with that of the non-CDHP population—shown in Table 2 by age, plan type, and Maryland region—is influenced by the availability of CDHPs from employers and insurers, as well as by consumer preferences for these products. The distributions of the two enrollee populations by age are fairly similar, although 21–45-year-olds are slightly less likely to be in the CDHP group (21 percent of 21–45-year-olds are in CDHPs versus 23.3 percent of 46–64-year-olds and 24 percent of those less than 21 years of age). This is somewhat contrary to expectations that younger, healthier adults would be more likely to select high-deductible plans and might be influenced by the availability of these plans to this age group through employers.

[5] Claxton G, et al. Employer Health Benefits: 2008 Annual Survey. Available at http://ehbs.kff.org/, Accessed May 19, 2009.

[6] There are no Maryland-specific data available on the percent of employers offering CDHPs.

[7] These are individuals with claims in the Maryland MCDB, indicating they have used at least one service by a health care professional in 2007.

[8] As insurers offered these new products, there were initial adjustments in terms of classification and coding, so enrollment figures prior to 2007 need to be viewed with caution, making calculation of precise annual growth rates problematic.

TABLE 2. CDHP and Non-CDHP Enrollees and Users in Maryland's Small Group Market, Persons Less Than 65 Years of Age, by Age, Plan Type, and Region, 2007

		CDHP	Non-CDHP	CDHP as Percentage of Total
NUMBER OF ENROLLEES, end of 2007		94,215	325,740	22.4%
AGE	Less than 21 years	27,228	86,972	23.8
	21–45	38,063	143,326	21.0
	46–64	28,924	95,442	23.3
PLAN TYPE	HMO	58,027	238,614	19.6
	PPO	36,188	87,126	29.3
REGION	Baltimore Metropolitan Area	49,651	141,045	26.0
	National Capital Area	22,706	100,002	18.5
	Other Maryland Areas	21,858	84,602	20.5
NUMBER OF USERS, end of 2007		46,951	261,245	15.2
NUMBER OF USERS, enrolled all year		20,696	217,207	8.7
PERCENTAGE OF ENROLLEES WITH USE		49.8%	80.2%	—

SOURCE: Enrollee counts are from payer submissions to MHCC. User counts are from the 2007 Maryland MCDB.

NOTE: The percentage of enrollees with use is calculated using the number of users at the end of 2007, because this is most comparable with the enrollment figures.

HMO enrollees, compared with PPO enrollees, were less well represented in CDHPs—20 percent of HMO enrollees are in a CDHP compared with 29 percent of PPO enrollees. An examination of the residence of enrollees by plan type shows substantial differences: CDHPs appear to be more common among Baltimore Metropolitan Area residents than among National Capital Area residents, with CDHPs accounting for 26 percent of enrollment in the Baltimore Metropolitan Area compared with 18.5 percent in the National Capital Area. This difference in CDHP enrollment is likely due, at least in part, to the relatively larger market presence of insurers offering CDHPs in the Baltimore Metropolitan Area than in the National Capital Area. Small group enrollees in other parts of Maryland were more equally represented in the two types of plans, with almost one-fourth in CDHPs.

Table 2 also provides counts of users of professional medical services or prescription drugs, in both the CDHP and non-CDHP enrollee populations. The larger count is for those users who were enrolled as of the end of 2007, and is most comparable with the enrollee counts. Using these figures, we show the user rate, or percent of enrollees who used a professional medical service during 2007. The user rate is markedly higher for non-CDHP enrollees—80.2 percent of these enrollees used at least one service, compared with only 49.8 percent of CDHP enrollees. However, to examine more closely the spending by the user population, we limit the analysis to those persons who were enrolled for the full year.

HOW MUCH DO CDHP AND NON-CDHP USERS SPEND ON MEDICAL SERVICES? One of the drivers behind CDHP growth has been the belief that their structure—with high deductibles or lack of first-dollar coverage—would help to contain cost growth. Premiums for CDHP products have been lower than premiums for all plans, because of their high cost-sharing and the expectation of possibly lower utilization. In 2007, single premiums for CDHPs (including large and small group market products as well as HMO and non-HMO) averaged approximately 80 percent of premiums for all plan types nationally.[9] Premiums for CDHP products rose only marginally in 2008, and the changes were not statistically significant.

[9] Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits 2007 Annual Survey and 2008 Annual Survey." The survey reports premiums for high-deductible health plans with a savings option.

TABLE 3. Premiums for Employee-Only Policies (with Riders), Maryland Small Group Market, 2007

ANNUAL PREMIUMS	CDHP	Non-CDHP
HMO	$1,490	$4,560
PPO	2,422	6,348

SOURCE: MHCC. "Summary of Carrier Experience for the Year Ending December 31, 2008," May 21, 2009.

In Maryland's small group market, the differences in premiums for non-CDHP plans compared with those of CDHP plans have been even larger than those observed nationally. In 2007, employee-only premiums for small group market HMO-HSA plans (including riders) averaged $1,490, compared with $4,560 for other HMO plans, and PPO-HSA premiums (including riders) averaged $2,442 versus $6,348 for other PPO plans (Table 3).

TABLE 4. Comparison of Enrollees in Maryland Small Group Market, by CDHP versus Non-CDHP, 2007

	CDHP	Non-CDHP
NUMBER OF ENROLLEES, end of 2007	94,215	325,740
Percentage with any professional services or prescription drug use	49.8%	80.2%
Mean annual insurer payment per enrollee	$562	$1,303
Percentage of enrollees with at least one hospitalization	3.5%	5.6%

NOTE: Annual expenditures reported in this Spotlight do not include hospital, dental, and other facility services, and durable medical equipment. These sectors accounted for approximately 47 percent of spending for the privately insured.

In Table 4, information on user rates and average expenditures for users provides initial information useful toward understanding these premium differences between CDHPs and non-CDHPs. Of the 94,215 CDHP enrollees, only half used professional services or prescription drugs, compared with more than three-quarters of the approximately 326,000 enrollees in more traditional plans. The percentage of enrollees with one or more hospitalizations also was lower among CDHP enrollees than non-CDHP enrollees: 3.5 percent versus 5.6 percent. Given the differences in use rates and benefit structures, the estimated mean payment by insurers for professional services and prescription drugs used by CDHP enrollees (users and non-users) was less than half that for non-CDHP enrollees—$562 compared with $1,303.

In order to examine spending in more detail while controlling for health status, individuals were assigned to one of three health risk categories according to the number and mix of diagnoses recorded on their provider claims.[10] The distribution across these risk categories for CDHP and non-CDHP users is shown in Table 5, with approximately one-third of each of the plan populations falling into each of the three risk groups. While there are no differences in the distribution of risk scores among the user populations, it is likely that there are differences in this expenditure risk measure when all enrollees are considered, if it is assumed that enrollees with no expenditures have a low risk of requiring expenditures for health care.

For persons who used health care services in 2007, total per-user spending on professional services and prescription drugs was slightly lower for those in CDHPs than for those in non-CDHPs—$1,969 for the former and $2,113 for the latter, a difference of 7 percent (Table 5). There was an even greater difference in spending on prescription drugs: average spending per user was $850 for persons in CDHPs and $1,004 for persons in more traditional plans, a difference of 18 percent. In fact, average spending for professional services was nearly identical in the two types of plans—differing by less than 1 percent. Within both insurance categories and for both professional services and prescription drugs, mean expenditures increased markedly by risk. High-risk users in both CDHPs and non-CDHPs spent about 5 times as much as low-risk users, on average. The relative difference between low-risk and high-risk users was highest for prescription drugs (i.e., the ratio of mean drug expenditures for high-to-low risk CDHP users was 5.4 and for other users 5.6 [data not shown]). It appears that CDHP enrollees are less likely to use services, but, once they use services, the differences between the two groups diminish. As mentioned earlier, there has been speculation that CDHPs would attract healthier individuals with lower spending, and this is supported by these data.

[10] Risk scores are ratings based upon the Chronic Illness and Disability Payment System (CDPS). See Kronick R, Gilmer T, Dreyfus T, and Lee L. "Improving Health-Based Payment for Medicare Beneficiaries: CDPS," *Health Care Financing Review*, Spring 2000, 21(3): 29–64. The CDPS includes weights based on total spending, including inpatient, drug, and provider services. It is used here based on diagnoses from provider claims only.

TABLE 5: Comparison of Expenditures in Small Group Market, by CDHP and Non-CDHP, for Users by Risk Status, 2007

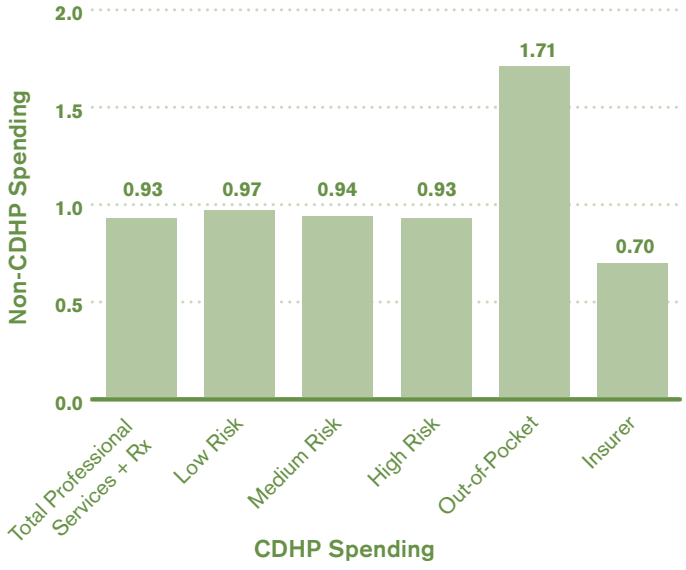
	CDHP Users				Non-CDHP Users			
	All Users	Low Risk	Medium Risk	High Risk	All Users	Low Risk	Medium Risk	High Risk
		Percentage of users by risk				Percentage of users by risk		
PERCENTAGE OF USERS	**100.0%**	34.6%	30.3%	35.0%	**100.0%**	34.5%	30.1%	35.4%
PERCENTAGE OF ENROLLEES	**49.8**	17.2	15.1	17.4	**80.2**	27.7	24.1	28.4
MEAN EXPENDITURES, PROFESSIONAL SERVICES AND PRESCRIPTION DRUGS ($)								
Total	**$1,969**	$721	$1,467	$3,636	**$2,113**	$743	$1,558	$3,919
Out-of-Pocket	**836**	424	747	1,321	**489**	217	419	813
Insurer	**1,132**	297	720	2,315	**1,624**	525	1,139	3,106
MEAN EXPENDITURES, PROFESSIONAL SERVICES ($)								
Total	**1,119**	427	844	2,041	**1,109**	409	823	2,032
Out-of-Pocket	**487**	252	435	765	**238**	105	203	397
Insurer	**632**	175	410	1,276	**871**	304	620	1,636
MEAN EXPENDITURES, PRESCRIPTION DRUGS[a] ($)								
Total	**850**	294	623	1,595	**1,004**	334	735	1,887
Out-of-Pocket	**349**	172	312	556	**251**	112	216	416
Insurer	**500**	122	310	1039	**753**	221	519	1,470
Percentage of Users with at least One Hospitalization	**7.0%**	0.7%	3.8%	16.0%	**7.0%**	0.7%	3.6%	16.1%

NOTES: Includes full-year users only. Users are defined as those with professional services use who may or may not also have prescription drug spending. Annual expenditures reported in this Spotlight do not include hospital, dental, and other facility services, and durable medical equipment. These sectors accounted for approximately 47 percent of spending for the privately insured.

[a] Prescription drug expenditures may be understated because enrollment by type of plan (CDHP versus non-CDHP) cannot be determined for persons with prescription drug spending but no spending on professional services. Such individuals are excluded from the analysis.

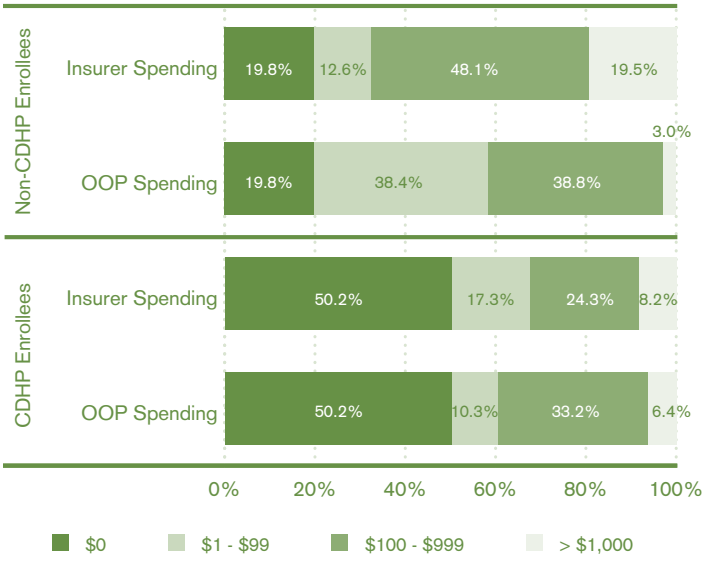
Because of the higher deductibles required by their plans, CDHP users had average OOP medical expenditures that were 70 percent higher than those for non-CDHP users ($836 versus $489 for both professional services and prescription drugs). As a percentage of total expenditures, CDHP users, on average, paid for two-fifths of their expenses out-of-pocket (42 percent), while non-CDHP users were responsible for just less than one-quarter of the total (23 percent). The proportion paid by the individual was similar for professional services alone and for drug expenses alone. Mean OOP expenses were higher for CDHP users than for other insured in each comparable risk category; for both types of coverage, the proportion of total spending paid by the user decreased as expenditures (and risk) increased. As an absolute amount, the average OOP burden was highest for high-risk CDHP users, at $765 for professional services, and $556 for prescription drugs.

FIGURE 1. Ratio of CDHP to Non-CDHP Spending for Users Only, by Risk Status and Financial Responsibility



In Figure 1, the ratio of spending for CDHP users and users covered by traditional plans is shown by risk category and by financial responsibility. A ratio equal to or close to one indicates that spending is similar under the different plan types; a ratio under one signifies that CDHP spending is lower and a ratio greater than one that it is higher. The ratio of 0.93 for total spending (professional services and prescription drugs combined) means that, overall, per user spending was 7 percent lower in CDHP than in non-CDHP. The bars representing the three risk categories show that spending differences are modest and even less pronounced within risk categories, particularly for low risk persons, and the same for those in the high risk category. Spending differences between the two groups of privately insured were most pronounced as regards financial responsibility. Because of the high-deductible structure of CDHPs, total OOP spending was 71 percent higher for CDHP users than for those in more traditional plans. Conversely, insurer spending was 30 percent lower for these individuals.

FIGURE 2. Out-of-Pocket Spending and Amounts Reimbursed by Insurer for CDHP and non-CDHP Enrollees, 2007



Hospitalization rates were the same for CDHPs and non-CDHPs, with 7 percent of each user group having been hospitalized at least once during 2007 (see Table 5). The low level is not surprising, given that hospitalization in the less-than-65-years-of-age population is a relatively rare event and usually is not elective.[11] While there has been conjecture that high-deductible plans will discourage use of primary and preventive care, the similar rates of inpatient hospitalization across CDHPs and non-CDHPs suggest that any disincentives are not contributing to a need for inpatient services. No differences appear when examined separately by risk level.

The expenditure comparisons reveal that the main spending differences between CDHP users and those in other plans lie in the fact that the relative financial burden falls on individuals rather than insurers. In Figure 2, we examine the extent to which individuals and insurers have either very low spending or relatively high spending for the two types of plans. In contrast to Table 5, which included only users, here we include all enrollees, regardless of their spending. A major difference between CDHP enrollees and those in more traditional plans is the proportion with no spending—50 percent for the former and 20 percent for the latter. An additional 10 percent of CDHP enrollees spent less than $100 out-of-pocket compared with 38 percent of non-CDHP enrollees who used a professional service but still spent less than $100 out-of-pocket. Thus, for OOP expenses, when we include zero spending, the proportion of individuals who spent less than $100 out-of-pocket is similar for CDHP and non-CDHP enrollees—60 percent and 58 percent, respectively. At the other end of the spending distribution, CDHP enrollees were twice as likely as non-CDHP users to spend $1,000 or more out-of-pocket (6 percent versus 3 percent). Insurer spending by enrollees in the two types of plans contrasts sharply with OOP spending. For two-thirds of CDHP enrollees, insurers spent less than $100 (including the 50 percent who had no spending at all), only slightly greater than they spent for non-CDHP enrollees, of whom 63 percent had less than $100 spent on their behalf (again, including the 20 percent of zero spenders). However, insurers spent $1,000 or more for nearly one-fifth of non-CDHP users, compared with only 8 percent of CDHP users.

[11] Nationally, 7.2 percent of persons had a hospitalization in 2006. "Statistical Brief #229, National Health Care Expenses in the U.S. Civilian Noninstitutionalized Population, 2006," Agency for Healthcare Research and Quality. Available at http://www.meps.ahrq.gov/mepsweb/data_files/publications/st229/stat229.pdf.

WHAT'S NEXT FOR CDHPs? It is likely that we will continue to see growth in CDHPs in the near future, both nationally and in Maryland, but that overall growth, will continue to be modest—large relative growth, but building on a small base. Among firms not offering a high-deductible product in 2008, only 4 percent reported that they were "very likely" to offer an HSA-qualified high-deductible plan in the next year, but another 21 percent said that they would be "somewhat likely" to offer this type of plan.[12] The extent of growth will ultimately depend not only on firms' willingness to offer these plans but also on employees' willingness to select them. While the small group market may offer CDHPs a particularly strong foothold in Maryland, there might still be reluctance among some workers to select a plan with a high deductible. Nationally, of firms offering in 2008, 39 percent indicated the biggest challenge was in educating employees or communicating the change in benefits. And, for many workers, high-deductible plans may be a riskier option in terms of potential financial burden. The data presented in this Spotlight show that, for persons who use any care, OOP expenses are higher in CDHPs than in non-CDHPs, particularly at the highest spending levels and for persons in worse health. At the lower end, the larger financial burden is largely mitigated, on average, by the lower percentage of persons in CDHPs who use any services. The extent to which employees are willing to take on this added risk may depend in part on whether there are overall cost savings and how much of these are passed on to the consumer in terms of lower premiums or increased employer contributions to HSAs. The shape of any health reform initiative as well as any associated changes in tax treatment of benefits will also play a role either in spurring or diminishing the spread of CDHPs.

With respect to the impact of high-deductible plans on health care access, costs, and quality, the jury is still out. Initial evidence supports earlier contentions that HSAs linked to high-deductible plans are more popular among higher income consumers.[13] Assessments of the impact on utilization and costs are mixed, with limited evidence to support expectations of lower costs.[14] Even in "full replacement" situations—in which an employer offers only a CDHP and no risk selection can occur—cost savings have been documented in the first year but not necessarily over the longer term. The data presented in this Spotlight suggest similar costs across CDHPs and other plans on a per-user basis; coupled with lower use rates, there is some room for cautious optimism about the potential for cost savings.[15] Employers may need to explore avenues for making these products more attractive to lower-income workers, for example, making relatively larger HSA contributions for low-wage employees in order to enhance their savings potential. The expectation that small employers will fund HSAs needs to be more fully investigated. Detailed data from the Maryland Health Insurance Plan, launched in September 2008, show that, even when only CDHP products are offered, virtually no employers are contributing to the health savings accounts. Employers also may need to increase the amount of available information about different options as well as to increase educational initiatives. Findings from a small study of one employer indicate that enrollees in high-deductible CDHPs are no more likely than non-CDHP enrollees to use information to support their decision-making and often made decisions that were inappropriate from a health perspective.[16] In this study, workers in the high-deductible option were more likely than their traditionally insured counterparts to forego use of high-priority services and, in particular, to discontinue use of prescription drugs needed for control of chronic conditions.

More evidence is needed to resolve a host of questions about the impact of these plans on cost, access, and quality. Are CDHP enrollees who do not use services more cost-conscious and better decision-makers, or are they simply healthier? Do

[12] Claxton G, Gabel J, DeJulio B et al., "Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises in Small Firms," *Health Affairs,* September 14, 2008.

[13] U.S. Government Accountability Office, "Health Savings Accounts: Participation Increased and Was More Common Among Individuals With Higher Incomes," GAO-08-474R, 2008.

[14] Beeuwkes Buntin M, Damberg C, Haviland A, Kapur K, Lurie N, McDevitt R, and Marquis MS, "Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality," *Health Affairs*, Web Exclusive, Vol. 25, No. 6, November/December 2006, pp. w516–w530. Parente ST, Feldman R, Yu X, "Impact of Full Replacement with Consumer Driven Health Plans on Total Health Care Cost and Use of Preventive Services," Final report for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, December 2008.

[15] An important caveat is that the data used on the proportion of the population using services and the level of use come from two different sources and thus may not be strictly comparable. Also, because individuals may not file claims unless until they have reached their deductibles, there may be an underrepresentation of smaller claims from persons with high-deductible plans, lowering average spending estimates for CDHP enrollees relative to those in plans with lower deductibles.

[16] Hibbard, JH et al. "Does Enrollment in a CDHP Stimulate Cost-Effective Utilization?" *Medical Care Research and Review*, Vol. 65, No. 4, August 2008.

CDHPs deter enrollees from using cost-effective preventive and primary care, saving short-run costs but costing more in the long term? Do low-income enrollees in high-deductible plans face larger financial burdens without benefiting from the savings and tax advantages associated with HSAs? Does the exit of healthier individuals from traditional plans cause an increase in premiums for those plans, as average risk for those remaining in traditional coverage rises?[17]

For high-risk patients with significant health care spending, patients covered by CDHP and non-CDHP products encountered similar total spending levels. OOP spending by individuals covered by CDHP products accounted for significantly more of the total, as is intended under the product's design. These results may suggest that the emphasis on greater patient accountability in the product design has not affected patient spending patterns. Expected costs savings may be less than some carriers' cost models have predicted. Recent premium filings with the Maryland Insurance Administration for enrollments after July 2009 show significant price increases over 2008 levels for some carriers. These increases, some in the range of 30 percent, suggest that some insurance carriers have not yet perfected their utilization models for the new products. As is characteristic with a new product, it is possible that volatility will continue as employers "sample" CDHP products and enrollees "learn" how to align health care utilization with incentives in the product.

[17] Concerns that only the sick will be left in traditional plans, must be qualified in CSHBP because 22 percent of firms and 38 percent of workers in firms with fewer than 50 employees have access to multiple plans. MEPS-IC 2006.

MHCC is an independent regulatory commission administratively located within the Maryland Department of Health and Mental Hygiene.
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